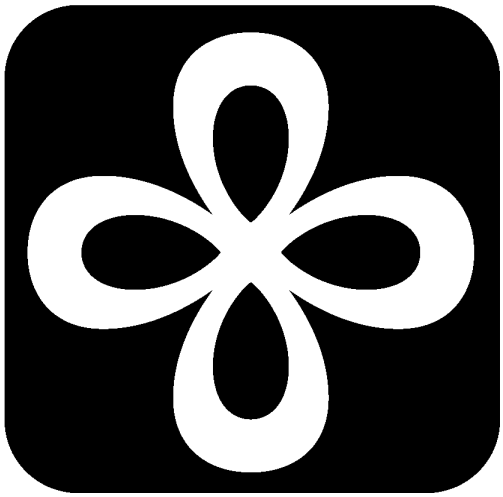
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Independent Laboratory Services

I. INDEPENDENT LABORATORIES ELIGIBLE TO PARTICIPATE

An independent laboratory is eligible to participate in the program providing it is certified under Medicare.

II. COVERAGE OF INDEPENDENT LABORATORY SERVICES

Payment is made for medically necessary laboratory services provided by independent laboratories certified to perform under Medicare.

Payment is made directly to the laboratory for services provided to Medicaid recipients. No payment will be made to a physician for services provided by the laboratory. The laboratory must do its own billing to Medicaid.

III. BASIS OF PAYMENT FOR LABORATORY SERVICES

Payment for services rendered by an independent laboratory is based on a fee schedule.

IV. PROCEDURE CODE AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS) which is based on the most recent edition of *Current Procedural Terminology* (CPT). The five-position procedure code must be followed by one of the following modifiers, if applicable:

EP Service as the result of an Care for Kids (Early and Periodic Screening, Diagnosis and Treatment) physical

FP Family planning service

Claims submitted without a procedure code and appropriate ICD-9-CM diagnosis code will be denied.

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check both "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by ACS.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)

Complete the "attachment control number" with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

Do not attach a paper claim.

Mail the *Claim Attachment Control* with attachments to:

ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

Pay-to-Provider Number

Recipient Name _____

Recipient State ID Number

Date of Service ____/____/_____

Type of Document

_____

_____

_____

RETURN THIS DOCUMENT WITH ATTACHMENTS TO:
ACS State Healthcare
P.O. Box 14422
Des Moines, IA 50306-3422

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following pages.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

REMITTANCE ADVICE

(1.) TO: [redacted] (2.) R.A. NO.: 0000006 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: [redacted] (5.) PAGE: 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* (6.) CLAIM TYPE: HCFA 1500						* (7.) CLAIM STATUS: PAID							
ORIGINAL CLAIMS:			(10.)			(11.)	(12.)	(13.)	(14.)	(15.)		(16.)	
[redacted] (8.)	[redacted]	(9.) [redacted]	4-96331-00-053-0038-00			38.00	0.00	16.06	0.00	860600608B		900	000
		(17.) 01	(18.) 10/3 (19.)	99212	(20.) 1	(21.) 38.00	(22.) 0.00	(23.) 16.06	(24.) 0.00	(25.) [redacted]			000 000
[redacted]	[redacted]	[redacted]	4-96348-00-018-0060-00			50.00	0.00	35.26	0.00	860600608B			000 000
		01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[redacted]	(26.)	F	000 000
		02	11/15/96	90782	1	9.00	0.00	2.08	0.00	[redacted]		F	000 000

(27.)

REMITTANCE TOTALS					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	---------	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(28.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 14 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FISCAL AGENT RESPONSE

Provider Signature/Date:	**MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422**	**ACS Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR ACS USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 20 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:	4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:	Provider/Representative Signature:
	Date:

FISCAL AGENT USE ONLY: REMARKS/STATUS

Return All Requests To:

ACS
PO Box 14422
Des Moines, IA 50306-3422

December 15, 1995

For Human Services Use Only

General Letter No. 8-A-AP(II)-577

Subject: Employees' Manual, Title VIII, Chapter , Appendix, Part Two

INDEPENDENT LABORATORY SERVICES MANUAL TRANSMITTAL NO. 95-1

Subject: Independent Laboratory Services Manual, Chapter F, Billing and Payment, pages 9 and 10, revised.

This General Letter is revised to add Independent Laboratory POS code 81 to the Place of Service code on Line 24B of the HCFA-1500 Health Insurance Claim Form and to correct spelling errors.

Date Effective

December 1, 1995

Material Superseded

Independent Laboratory Services Manual, Chapter F, pages 9 and 10, dated September 1, 1993, shall be removed from the manual and destroyed.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-68
Employees' Manual, Title 8
Medicaid Appendix

May 22, 1998

INDEPENDENT LABORATORY SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Independent Laboratory Services Manual***, Table of Contents (page 4), revised, and Chapter F, *Billing and Payment*, pages 1 through 17, revised.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Independent Laboratory Services Manual***, and destroy them:

Page	Date
Contents (page 4)	September 1, 1993
Chapter F	
1	September 1, 1993
2	Undated
3, 4	12/90
5-8	September 1, 1993
9, 10	December 1, 1995
11-13	September 1, 1993
14	Undated
15-17	06/18/93
18, 19	September 1, 1993

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-144
Employees' Manual, Title 8
Medicaid Appendix

June 15, 2000

INDEPENDENT LABORATORY SERVICES MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Independent Laboratory Services Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, page 1, revised; and Chapter F, *Billing and Payment*, pages 18 through 21, new.

Chapter E is revised to:

- Include medically necessary services.
- Clarify the basis of payment.
- Update the CPT reference.

Forms 470-3744, *Provider Inquiry*, and 470-0040, *Credit/Adjustment Request*, are added to Chapter F for provider convenience.

Date Effective

July 1, 2000

Material Superseded

Remove from ***Independent Laboratory Services Manual***, Table of Contents (page 4), dated May 1, 1998; and Chapter E, page 1, dated January 1, 1998, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-230
Employees' Manual, Title 8
Medicaid Appendix

August 26, 2003

INDEPENDENT LABORATORY SERVICES MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***INDEPENDENT LABORATORY SERVICES MANUAL***, Table of Contents, page 4, revised; Chapter E, *Coverage and Limitations*, page 1, revised; Chapter F, *Billing and Payment*, pages 4, 8, 18, 19, and 21, revised; and page 10a, new.

This revision changes the modifiers to standardized HCPCS modifiers in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

EP Service as the result of a Care for Kids (Early and Periodic Screening. Diagnosis and Treatment) physical
FP Family planning service

Chapter F has been revised to add instructions for form 470-3969, *Claim Attachment Control*, used to submit paper attachments for an electronic claim.

Both chapters have been revised to replace reference to "Consultec" with "ACS."

Date Effective

July 1, 2003

Material Superseded

Remove from ***INDEPENDENT LABORATORY SERVICES MANUAL***, and destroy them.

Page	Date
Table of Contents (page 4)	July 1, 2000
Chapter E	
1	July 1, 2000
Chapter F	
4, 8	May 1, 1998
18	July 1, 2000
19 (470-3744)	4/00
21 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet Access, you may request a paper copy of this Manual Transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.